DELAWARE HEALTH AND SOCIAL SERVICES
Division of Public Health
Office of Emergency Medical Services

Registration for Automatic External Defibrillator Service Provider

Delaware Early Defibrillation Program

First State, First Shock! Program

Print Clearly and Answer All Sections Completely

Type of Application (Check One):
❑Initial Application (complete all sections) ❑Change (complete appropriate section)

Agency Name:

Service Coordinator:

Street Address:

Daytime Telephone Number:

Mailing Address (if different from above):

Pager:

City: DE Zip:

FAX:

Type of Service:
❑ EMS/Fire/Rescue ❑ Law Enforcement/Corrections ❑ Business/Industrial
❑ Senior/Youth Center ❑ School/Higher Education ❑ Government
❑ Healthcare ❑ Public Assembly
❑ Other (Describe):_____

Provide the following attachment (All entities except Fire/EMS/Law Enforcement):

– Statement from Business or Agency Chief Officer supporting program implementation.

Signature of Service Coordinator:

Date:

OEMS Use Only Below This Line

Reviewed By (Print):

Date:

Status: ❑Entered into system ❑Awaiting additional information

Comments:

FILENAME: AED Application.doc

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